Form T-1a	Kentucky Law Enforcement Council *PHYSICIAN'S MEDICAL RELEASE FORM*	Office Use Only

Mail: Kentucky Law Enforcement Council
Funderburk Building
521 Lancaster Ave.
Richmond, KY 40475-3102

Phone: 859-622-6218 **Fax:** 859-622-5943

INSTRUCTIONS: This form must be completed by a physician, physician assistant or Nurse Practitioner, prior to the applicant participating in the physical ability, **IF** the applicant checks "yes" on any question between numbers 1-10 on the Form T-1. **If this form is required and not completed, the applicant will be sent home.**

NAME: _____

Date of Birth _____ **SS#**_____

Peace officers in the Commonwealth of Kentucky are required to perform a variety of essential physically demanding tasks including the following:

- o Walking for extended periods
- o Short sprints
- o Long pursuit running lasting over 2 minutes
- o Jumping over and around obstacles
- o Lifting and carrying objects sometimes up and down stairs
- o Using hands and feet in use of force situations
- o Using force in short and long term (greater than 2 minutes) efforts
- o Bending and reaching
- o Dragging people and objects as in extracting victims from vehicles

To measure an individual's capacity to perform these critical tasks all applicants must undergo a physical ability test consisting of the following items:

- o 1.5 mile run to measure aerobic power
- o 300 meter sprint to measure anaerobic power
- o Sit ups to measure abdominal muscular endurance
- o Push ups to measure upper body muscular endurance
- o Free weight bench press to measure upper body absolute strength

Your professional opinion is requested as to whether the individual can safely participate in physical ability testing.

PLEASE CHECK ONE:

____ There are no contraindications to the individual either 1) being capable of performing the essential physical tasks or 2) being capable of undergoing the physical ability test items.

____ There are contraindications and it is recommended that the individual **not** participate in the physical ability test items.

I hereby verify that the above information is true and accurate.

Signed this _____ day of _____, 20_____.

_____
Signature of Physician, Physician Assistant or Nurse Practitioner

_____
Printed Name of Physician, Physician Assistant or Nurse Practitioner